



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ALLAN J CHERNOV MD  
P O BOX 121589  
ARLINGTON TX 76012

#### **Respondent Name**

SOUTHERN VANGUARD

#### **Carrier's Austin Representative Box**

Box Number 17

#### **MFDR Tracking Number**

M4-12-2287-01

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "New Rule §134.204(i) describes all six examinations performed by designated doctors, but directs the reimbursement for MMI/IR examinations performed by designated doctors to subsection (j), and excludes reimbursement for MMI/IR from the tiered reimbursement structure of subsection (i) for multiple examinations performed by the designated doctor. MMI/IR examination performed by designated doctors do not result in the tiering of the non-MMI/IR examinations. When conducting exams for issues other than the MMI/IR, apply the new tiered reimbursement method described in rule 134.204(i) to the remaining four exams. **Reimbursement for one of these exams is \$500.** When conducting more than one of these exams under the same request, the first exam is reimbursed at 100% of the fee for the exam, \$500; the second exam is reimbursed at 50% of the fee for the exam, \$250; and the subsequent exam(s) are reimbursed at 25% of the fee for the examination, \$125. **We seek full reimbursement for the outstanding balance of \$500.00** along with interest accrued according to Rule 134.803 Calculating Interest for Late Payments on Medical Bills."

**Amount in Dispute:** \$500.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a response for consideration to this dispute.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 23, 2011	99456-W6-RE	\$500.00	\$500.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 26, 2011

- 214 – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only) \$0.00
- 850-001 – DENIED: WORKERS' COMPENSATION BENEFITS HAVE BEEN DENIED BASED ON THE WORKERS' COMPENSATION LAW IN THE STATE THE CLAIM WAS FILED. \$0.00  
DENIED: WORKERS' COMPENSATION BENEFITS HAVE BEEN DENIED BASED ON THE WORKERS' COMPENSATION LAW IN THE STATE THE CLAIM WAS FILED.

Explanation of benefits dated October 5, 2011

- 14 – Duplicate claim/service
- 999 – \$500.00 OF THE CHARGES ARE DUPLICATES OF BILL #99996-H-1243002-0

## **Issues**

1. Is the respondent's denial adjustment reason codes supported?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

## **Findings**

1. The respondent denied the billing with reason code "214 – Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. (Note: To be used for Workers' Compensation only) \$0.00" and "850-001 – DENIED: WORKERS' COMPENSATION BENEFITS HAVE BEEN DENIED BASED ON THE WORKERS' COMPENSATION LAW IN THE STATE THE CLAIM WAS FILED. \$0.00 DENIED: WORKERS' COMPENSATION BENEFITS HAVE BEEN DENIED BASED ON THE WORKERS' COMPENSATION LAW IN THE STATE THE CLAIM WAS FILED." The respondent did not clarify or otherwise address or uphold the 214 or 850-001 claim adjustment codes upon receipt of the request for reconsideration or in the dispute resolution response, the Division will review the billing per the applicable Division rules and fee guidelines in 28 Texas Administrative Code §134.204 with the review of supporting documentation.

The Texas Labor Code §408.0041 states in (h)(1): (h) The insurance carrier shall pay for: (1) an examination required under Subsection (a) or (f) and the Texas Labor Code §408.0041 states in (a)(1)(2): (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any questions about: (1) the impairment caused by the compensable injury; (2) the attainment of maximum medical improvement.

2. The requestor billed the amount of \$500.00 for CPT code 99456-W6-RE with 1 (one) unit in Box 24G of the CMS-1500 for a Division ordered Extent of Injury Examination for date of service August 23, 2011. The Division order on the EES14 and DWC032 was to determine the extent of the employee's compensable injury. Review of the narrative documentation supports services rendered as billed. Per 28 Texas Administrative Code §134.204(i)(2)(A) and (k), the Maximum Allowable Reimbursement (MAR) for the 1<sup>st</sup> Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examination is \$500.00.
3. The respondent has previously reimbursed the requestor the amount of \$0.00 for the disputed CPT code 99456-W6-RE. Therefore, the requestor is entitled to reimbursement of \$500.00.

## **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$500.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ May 18, 2012 Date
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## **YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**